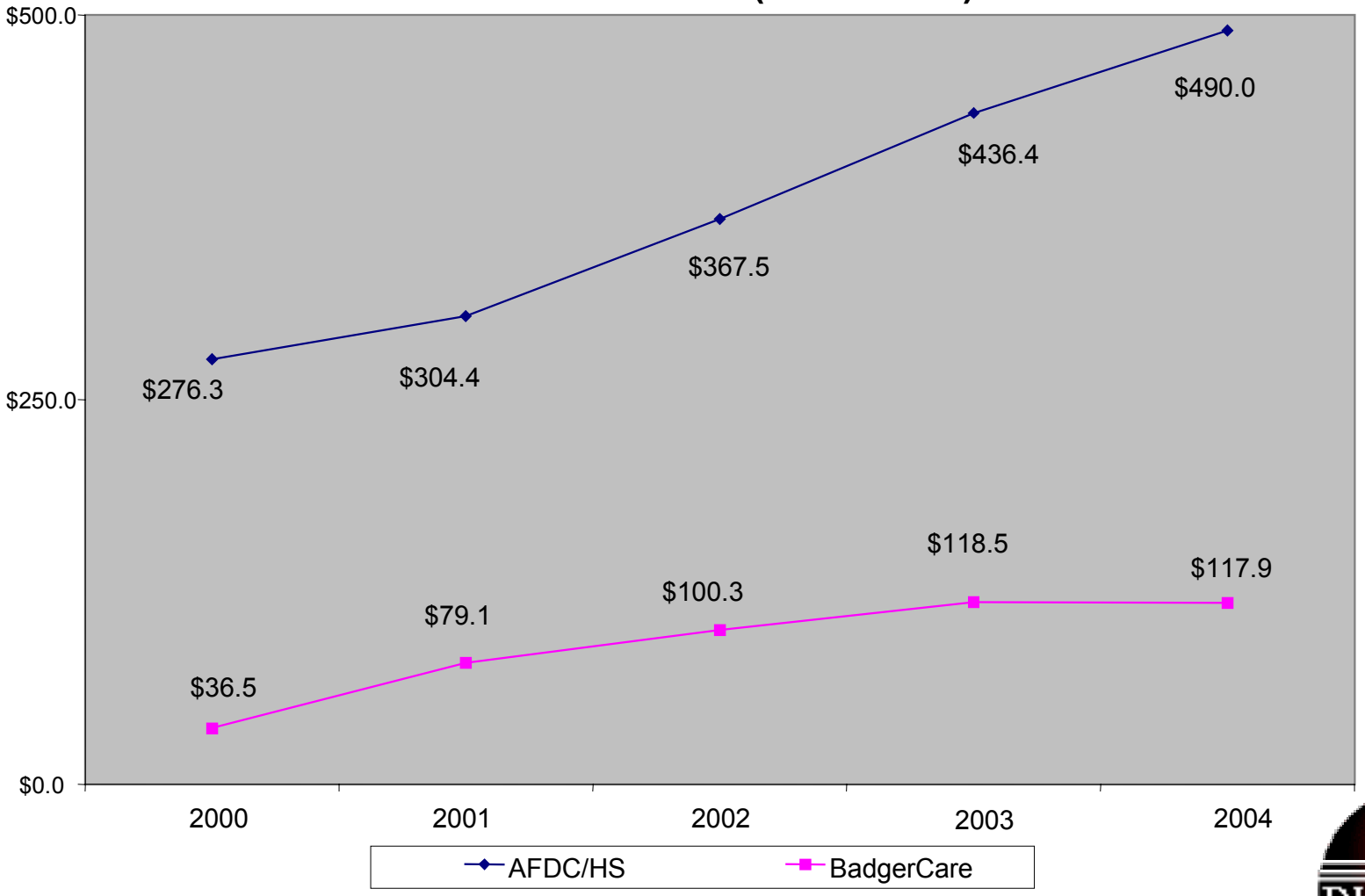
Managed Care

Managed Care

- The Medicaid program contracts with Health Maintenance organizations (HMOs) to provide comprehensive health services to recipients for a fixed, monthly capitation payment.
- Nationally, managed care is the predominant service delivery mechanism for Medicaid beneficiaries.
  - In 1992, fewer than 10% of Medicaid beneficiaries in the U.S. were enrolled in a managed care program.
  - Currently, 56% of U.S. Medicaid beneficiaries, approximately 19 million, are enrolled in managed care.

Annual Managed Care Capitation Payments by Eligibility Group
SFY 2000 - 2004 (in millions)



Managed Care Benefits

- Medicaid recipients enrolled in managed care programs are entitled to the same benefits as recipients not enrolled in managed care.
- HMOs must provide all Medicaid-covered services.
- Coverage of dental and chiropractic services varies by region.
- If an HMO does not cover dental and chiropractic services, it is provided to recipients on a fee-for-service basis.
- There are no copayments for recipients enrolled in managed care.

Managed Care Quality Assurance

- Federal regulations require that states have a written strategy for assessing and improving the quality of managed care services.
- States must periodically review the effectiveness of the strategy and update it as necessary.
- The strategy must include annual, external, independent reviews of the outcomes and timeliness of service and access to services.
- Medicaid contracts require the HMOs to have ongoing quality assessment and performance improvement programs.

Managed Care Quality Assurance

- In 2000, Medicaid implemented an automated performance measuring system called the Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS).
- MEDDIC-MS is unique nationally in that it does not require intrusive and expensive medical record review.
- MEDDIC-MS tracks quality improvement using validated encounter data to measure HMOs performance against standardized criteria.

Managed Care Quality Assurance

MEDDIC-MS Criteria include:

- Inpatient hospital and emergency room use by asthma patients
- Blood lead toxicity screenings for children
- Preventive dental services
- Diabetes care
- Childhood immunizations
- Mammography screenings
- Maternity care

Managed Care Quality Assurance

Reviews of MEDDIC-MS trends from 2000 to 2003 show:

- The prevalence of asthma remained unchanged but the use of emergency department services declined from 25.9% to 23.2 % and the use of inpatient hospital care declined from 7.6% to 4.9%.
- Blood lead toxicity screening rates improved, increasing from 59.9% to 69.1% for 1 year olds and from 47.7% to 50.9% for two year olds.
- For adult diabetics, the hemoglobin A1c testing rate improved from 45.5% to 63.2% and the lipid profile testing rate improved from 45.7% to 61.9%.
- Access to primary care remained high with just under 80% of enrollees having at least one visit.

Managed Care Quality Assurance

Reviews of MEDDIC-MS trends from 2000 to 2003 (Cont):

- The rate of mental health and substance abuse evaluations increased from 3.5% to 5%.
- Utilization of mental health day treatment provided by specialists increased from 5.8% to 7%
- Well child exam rates increased for children under 1 year from 69.9% to 95.8%.
- Well child exam rates under the HealthCheck program for children under age 2 receiving 7+ exams improved from 45.7% to 63.2%

Managed Care Quality Assurance

- Medicaid uses the information from MEDDIC-MS system to publish HMO report cards.
- The report cards are designed to be user friendly and can be used by recipients when selecting an HMO.
- The report cards rate the HMOs as above average, average or below average on five clinical performance indicators and four non-clinical performance indicators.

Managed Care Satisfaction Surveys

- Medicaid surveys HMO enrollees using a standardized survey called the consumer assessment of health plans (CAHPS), with state-specific modifications.
- In December 2003, the survey results indicated that 80% of enrollees were satisfied with 7 key indicators.
- HMO performance was highest in the “getting needed care” and “helpful clinic office staff” categories.

Managed Care Complaint & Grievance Process

- Medicaid has a formal process for responding to managed care enrollee's complaints and grievances.
- Recipients have a right to file a grievance with their HMO regarding the HMO's policies and procedures.
- The HMO must respond to the recipient's grievance in writing within 10 business days.
- The HMO's final response to the recipient's grievance must be in writing within 30 calendar days.
- Emergency grievances, when the situation places the health of the individual in serious jeopardy, must be resolved within 2 business days.

Managed Care Complaint & Grievance Process

- Recipients have the right to appeal the HMO's response to DHFS Ombuds or the Division of Hearings and Appeals.
- Ombuds act as liaisons between DHFS, HMOs and recipients to protect and promote the rights of all managed care recipients.

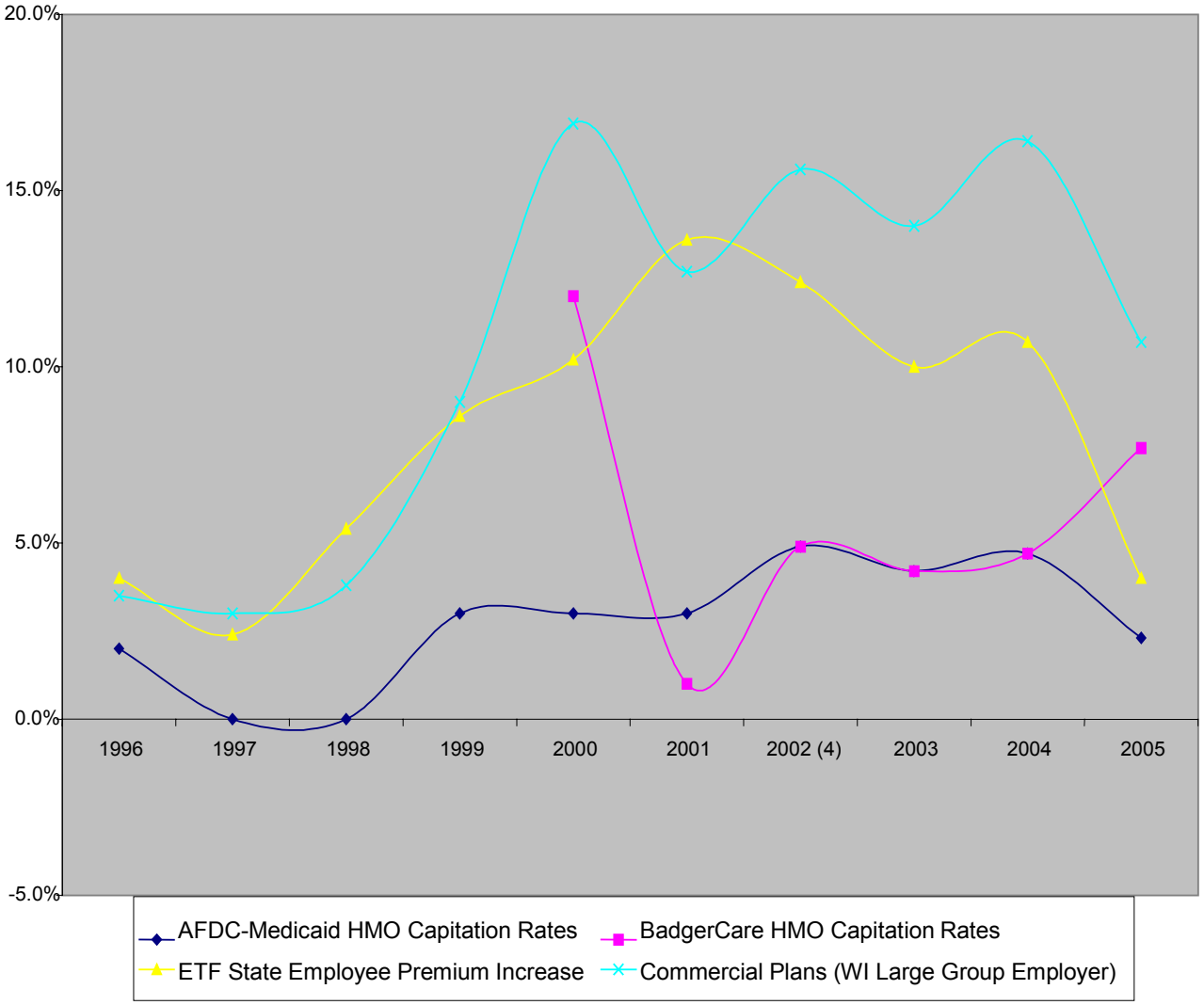
Managed Care Complaint & Grievance Process

- Ombuds have 7 working days to acknowledge receipt of the grievance in writing.
- HMOs have 10 working days to send requested information to the Ombuds.
- The recipient will receive written notice of the state's final decision on their grievance within 30 working days from the date the necessary information is received by the Ombuds.
- Filing a complaint does not affect the recipient's benefits.

Managed Care Capitation Payments

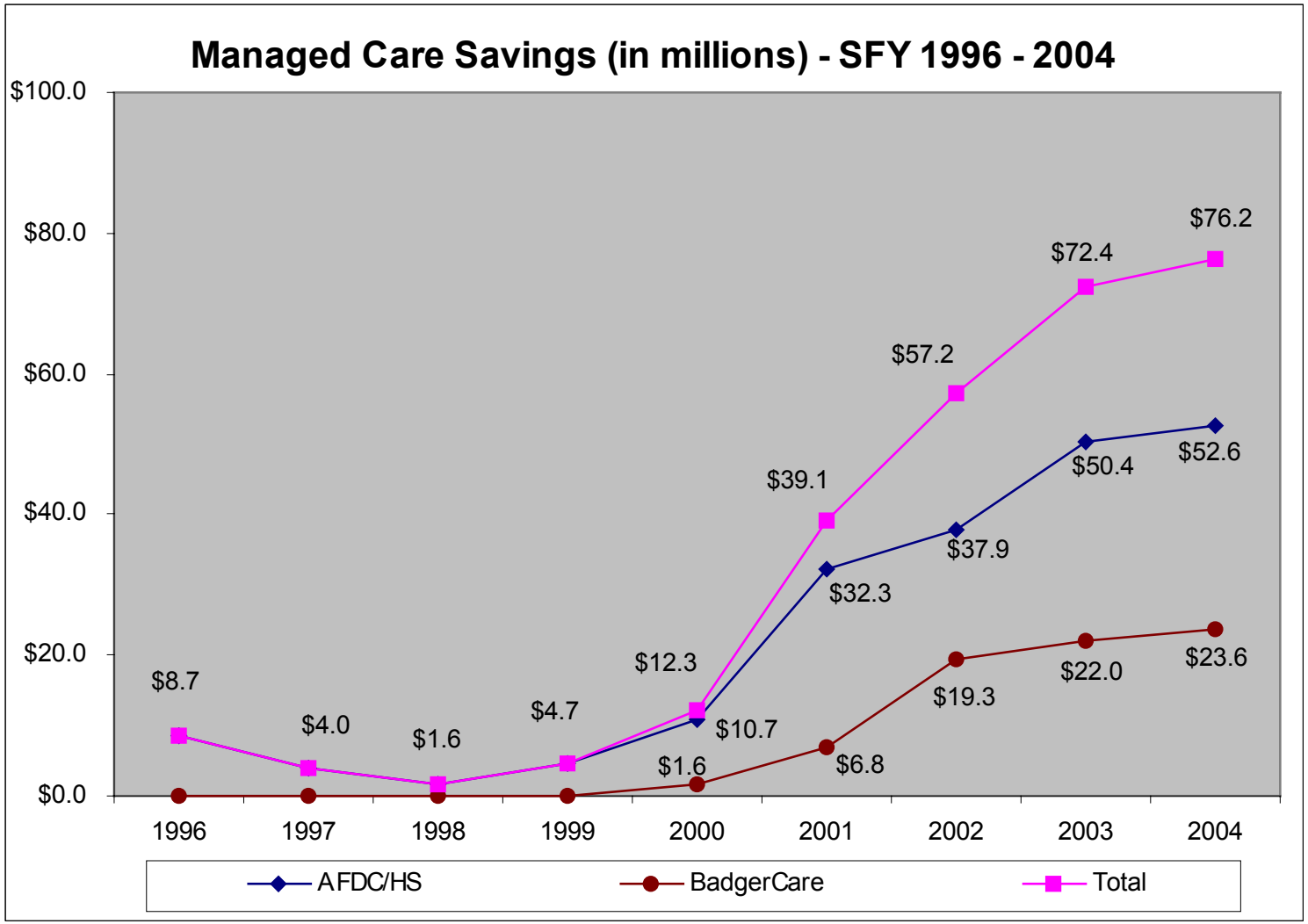
- Medicaid calculates separate capitation payment base rates for 14 regions in the state.
- The base rates are then weighted based on an enrollee's age and gender.
- Federal regulations require that captitation payments be actuarially sound. Capitation payment rate calculations that do not meet the criteria cannot be matched with federal funds.

Comparison of Medicaid, BadgerCare, ETF/State Employee and Commercial Plan Rate Increases



Managed Care Savings

- Because the HMOs contract with Medicaid to provide comprehensive care to recipients for a fixed payment, the HMO assumes the financial risks associated with the utilization of services.
- The delivery of services through an HMO may encourage the use of preventive services and improve the continuity and quality of care.
- For SFY 2004, it is estimated that the managed care capitation payments were 15.7% lower than the cost of equivalent fee-for-service care for the enrolled population.

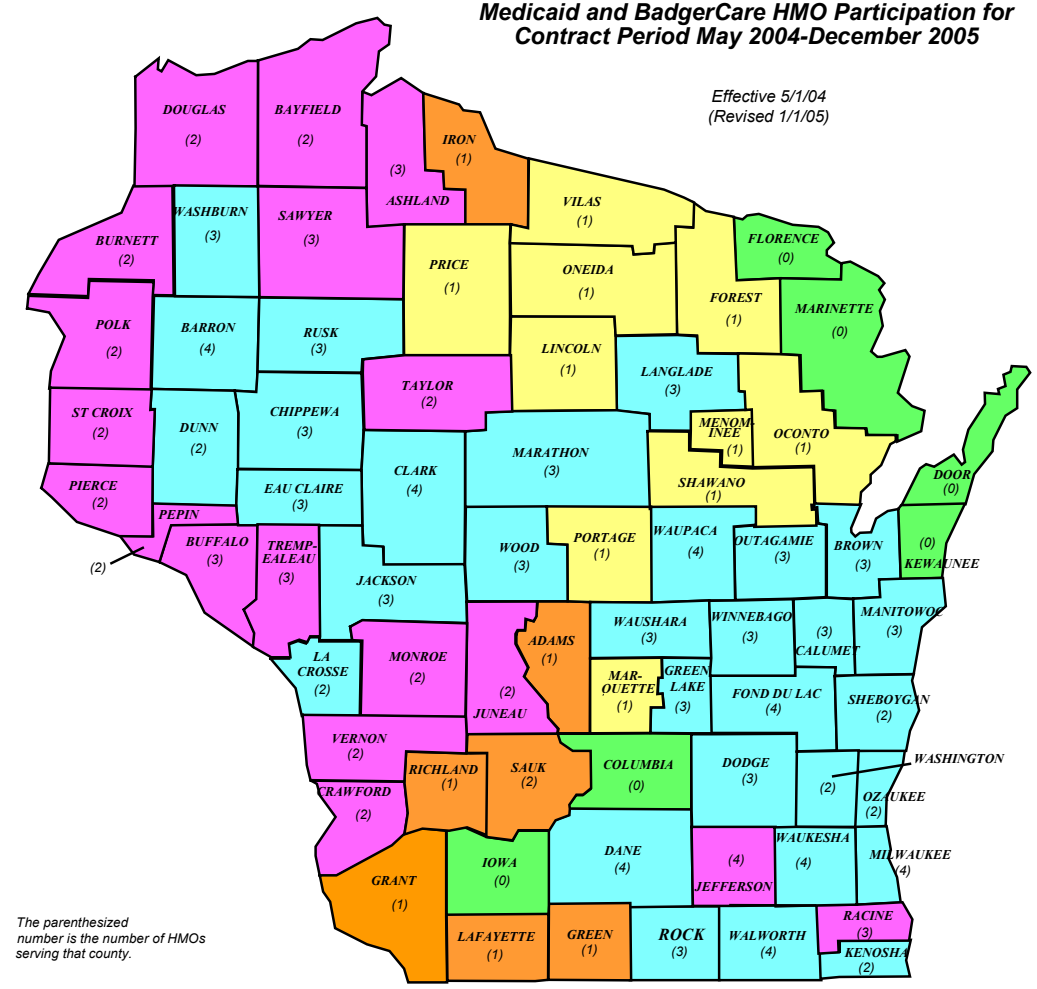

Managed Care Savings (in millions) - SFY 1996 - 2004
$100.0
$80.0
$60.0
$40.0
$20.0
$0.0
1996
1997
1998
1999
2000
2001
2002
2003
2004
$8.7
$4.0
$1.6
$4.7
$12.3
$39.1
$57.2
$72.4
$76.2
$1.6
$10.7
$32.3
$37.9
$50.4
$52.6
$6.8
$19.3
$22.0
$23.6
AFDC/HS
BadgerCare
Total

Managed Care Expansion

- HMOs do not serve Medicaid recipients in all areas of the state.
- Recipients must have a choice of at least 2 HMOs for mandatory enrollment.
- Wisconsin is applying for a federal waiver to allow mandatory managed care participation for recipients in certain rural areas, if the recipient is allowed to:
  - Choose from at least two physicians or case managers,
  - Obtain assistance from any other provider in an emergency,
  - Obtain services from a provider who is not part of the network, in certain circumstances.

Medicaid and BadgerCare HMO Participation for Contract Period May 2004-December 2005

Effective 5/1/04
(Revised 1/1/05)



The parenthesized number is the number of HMOs serving that county.

- Mandatory HMO counties (2 or more HMOs).
- Mandatory HMO for selected zip codes in county, voluntary or Fee-for-Service in other zip codes.
- Voluntary HMO counties (1 HMO).
- Voluntary HMO for selected zip codes in county, Fee-for-Service in other zip codes.
- Fee-for-Service counties (HMOs do not participate).

Mandatory Counties	31
Mandatory - Partial Counties	18
Voluntary Counties	10
Voluntary - Fee-for-Service Counties	7
Fee-for-Service Counties	6